# Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

## What is the purpose of the EPSDT program?

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a federal preventive health care benefit. The purpose of this program is to screen clients 20 years of age and younger in order to identify physical and/or mental health problems. If a physical or mental health problem is identified, the client should be treated or referred to an appropriate provider for treatment. EPSDT is designed to encourage continuing access to health care.

Access to and services for EPSDT are governed by federal rules at 42 CFR, Part 441, Subpart B.

HRSA's standard for coverage is that the services, treatment, or other measures must be:

- Medically necessary;
- Safe and effective; and
- Not experimental.

## Who can provide EPSDT screenings?

- Physicians;
- Advanced Registered Nurse Practitioners (ARNPs);
- Physician Assistants (PAs);
- Nurses specially trained through the Department of Health (DOH); and
- Registered nurses working under the guidance of a physician or ARNP.

## Who is eligible for EPSDT screenings?

HRSA covers EPSDT screenings provided to clients who:

- Are 20 years of age and younger; and
- Present a DSHS Medical ID card with one of the identifiers listed on the following page:

| Medical Program Identifier | Medical Program Name |
|---|---|
| CNP | Categorically Needy Program |
| CNP – Children's Health | CNP – Children's Health Program |
| CNP – CHIP | CNP – State Children's Health Insurance Program |
| LCP – MNP | Limited Casualty Program – Medically Needy Program |

**Note:** Please refer clients to their local Community Services Office (CSO) if they are 20 years of age and younger and their DSHS Medical ID card does not list one of the above medical program identifiers. The CSO will evaluate these clients for a possible change in their Medical Assistance program that would enable them to receive EPSDT screenings.

## Are clients enrolled in one of HRSA's Managed Care plans eligible for EPSDT?

**Yes!** EPSDT screenings are included in the scope of service provided by HRSA's managed care plans. Clients who are enrolled in one of HRSA's managed care plans will have an identifier in the HMO column on their DSHS Medical ID Card.

Please refer managed care clients to their respective managed care plan's primary care provider (PCP) for coordination of necessary preventive health care services and medical treatments, including EPSDT services. Clients can contact their plan by calling the telephone number indicated on their DSHS Medical ID card.

**Do not bill HRSA for EPSDT services. They are included in the managed care plan's reimbursement.**

## Primary Care Case Management (PCCM)

For the client who has chosen to obtain care with a PCCM, the identifier in the HMO column on their DSHS Medical ID card will be "PCCM." These clients must obtain or be referred for services through the PCCM. The PCCM is responsible for coordination of care just like the Primary Care Provider (PCP) would be in a plan setting.

**Note:** To prevent billing denials, please check the client's DSHS Medical ID card prior to scheduling services and at the ***time of the service*** to make sure proper authorization or referral is obtained from the PCCM.

## Billing for Infants Not Yet Assigned a Patient Identification Code (PIC)

Use the PIC of either parent for a newborn if the infant has not yet been issued a PIC. Enter indicator **B** in the *Comments* section of the claim form to indicate that the parent's PIC is being used for the infant. When using a parent's PIC for twins or triplets, etc., identify each infant separately (i.e., twin A, twin B), using a *separate claim form* for each. **Note: For parents enrolled in an HRSA managed care plan, the plan is responsible for providing medical coverage for the newborn(s).**

## What are EPSDT screenings?

EPSDT screenings are defined by federal rules as "regularly scheduled examinations and evaluations of the general physical and mental health, growth, development and nutritional status of infants, children and youth" that are provided as part of a health supervision program.

## What is included in an EPSDT screening?

At a minimum, EPSDT screenings must include:

- A comprehensive health and developmental history, updated at each screening examination;
- A comprehensive physical examination performed at each screening examination;
- Appropriate vision testing;
- Appropriate hearing testing;
- Developmental assessment;
- Nutritional assessment;
- Appropriate laboratory tests;
- Dental/oral health assessment; including:
    - ✓ How to clean teeth as they erupt;
    - ✓ How to prevent baby bottle tooth decay;
    - ✓ How to look for dental disease;
    - ✓ Information on how dental disease is contracted;
    - ✓ Preventive sealant; and
    - ✓ Application of fluoride varnish, when appropriate;
- Health education and counseling; and
- Age appropriate mental health and substance abuse screening.

Licensed providers may perform these components separately; however, HRSA encourages the provider to perform as many of the components as possible to provide a comprehensive picture of the client's health.

## Additional Screening Components

For fee-for-service clients, the following screening services may be billed in addition to the EPSDT screening components listed on the previous page:

- Appropriate audiometric tests (CPT codes 92552 and 92553);
- Appropriate laboratory tests, including testing for anemia; and
- Appropriate testing for blood lead poisoning in children in high-risk environments (CPT codes 82135, 83655, 84202, and 84203).

## How often should EPSDT screenings occur?

The following are Washington State's schedules for health screening visits. Payment is limited to the recommended schedules listed below:

- Five total screenings during the first year of the child's life. Below is a recommended screening schedule for children from birth to one year of age.

  - ✓ 1st Screening: Birth to 6 weeks old
  - ✓ 2nd Screening: 2 to 3 months old
  - ✓ 3rd Screening: 4 to 5 months old
  - ✓ 4th Screening: 6 to 7 months old
  - ✓ 5th Screening: 9 to 11 months old

- Three screening examinations are recommended between the ages of 1 and 2 years.
- One screening examination is recommended per 12-month period for children ages 2 through 6.
- One screening examination is recommended per 24-month period for children ages 7 through 20, except foster care clients, who receive a screening examination every 12 months and within 30 days of foster care placement or official relative placement through the Children's Administration.

## Foster Care Children

HRSA reimburses providers an enhanced flat fee of $120.00 per EPSDT screening exam for foster care clients who receive their medical services through HRSA's fee-for-service system. This applies to CPT codes 99381-99385 and 99391-99395 only.

DSHS updated the "other" column of the Medical ID Card by adding one of the following letters to indicate the child is in foster care:

- **D** (Division of Developmental Disabilities client in relative placement);
- **F** (Foster Care placement); or
- **R** (Relative placement).

**Effective for dates of service on and after July 1, 2006**, if the Medical ID card indicates the child is in foster care, the provider must bill one of the above screening codes with modifier 21 to receive the enhanced rate.

HRSA pays providers for an EPSDT screening exam for foster care clients without regard to the periodicity schedule when the screening exam is billed with modifier 21.

To receive the enhanced rate, providers are required to use either:

- The DSHS "Well Child Examination" forms for Infancy, Early Childhood, Late Childhood, and Adolescence [DSHS 13-683 A-E(x), 13-684 A-C(x), 13-685 A-C(x), and 13-686A-B(x)] (see Important Contacts section for information on obtaining DSHS forms); **or**
- Another charting tool with equivalent information.

To obtain paper copies of the Well Child Examination forms, follow the instructions found on page C.20 of this section.

To download an electronic copy of the Well Child Examination form, go to: http://www1.dshs.wa.gov/msa/forms/eforms.html.

## What are the time limits for scheduling requests for EPSDT screenings?

Requests for EPSDT screenings must be scheduled within the following time limits:

| If an EPSDT screening is requested through… | For clients who are… | Must be scheduled within… |
|---|---|---|
| HRSA's Managed Care plans, Primary Care Case Management (PCCM), or Primary Care Providers (PCPs) | Infants – within the first 2 years of life. | 21 days of request. |
| | Children – two years and older. | Six weeks of request. |
| | Receiving Foster Care – Upon placement | 30 days of request, or sooner for children younger than 2 years of age. |
| Community Mental Health Center, Head Start, substance abuse provider, or Early Childhood Education and Assistance Program (ECEAP) | Birth through 20 years of age | 14 days of the request. |
| **Providers must ensure that when medically necessary services are identified during any EPSDT screening examination, appropriate treatment or referrals are made.** | | |

## What if a medical problem is identified during an EPSDT screening?

If a medical problem is identified during a screening examination (see page C.5), the provider may:

- Refer the client to an appropriate HRSA provider or HRSA's Managed Care Plan provider, if applicable, for medical treatment; or
- Provide the service for the client (if it is within the provider's scope of practice).

> **Note:** If the provider is using the parent's PIC code to bill Evaluation and Management (E&M) codes 99201-99215 for an infant who has not yet been assigned a PIC code, the provider must use modifier HA in order to be reimbursed at the higher rate for EPSDT services. **Modifier HA must be the first modifier following the CPT or HCPCS code**. Any additional modifier may be listed second.

If the provider chooses to treat the medical condition on the same day as the screening exam, the provider must bill the appropriate level E&M code with modifier 25 in order to receive additional reimbursement for the office visit. Providers must bill using the appropriate ICD-9-CM medical diagnosis code that describes the condition found. **The E&M code and the EPSDT screening procedure code must be billed on separate claim forms.**

## Referrals

### Chiropractic Services

Eligible clients may receive chiropractic services when a medical need for the services is identified through an EPSDT screening. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary chiropractic services.

### Dental Services

Eligible clients may go to a dental provider without an EPSDT screen or referral.

### Orthodontics

Eligible clients may go to an orthodontic provider without an EPSDT screen or referral. HRSA reimburses for orthodontics for children with cleft lip or palates or severe handicapping malocclusions ***only***. HRSA does not reimburse for orthodontic treatment for other conditions.

### Fetal Alcohol Syndrome (FAS) Screening

FAS is a permanent birth defect syndrome caused by the mother's consumption of alcohol during pregnancy. FAS is characterized by cognitive/behavioral dysfunction caused by structural and/or chemical alterations of the brain, and/or a unique cluster of minor facial anomalies, and is often accompanied by growth deficiency.

As part of the EPSDT screen, every child six months of age or older should be screened for risk of exposure to maternal consumption of alcohol and for the facial characteristics of FAS. Children can be referred to a diagnostic clinic if there is known in-utero exposure to alcohol, or if there is suspicion of facial characteristics of FAS or microcephaly.

# Medical Nutrition Therapy

If an EPSDT screening provider suspects or establishes a medical need for medical nutrition therapy, eligible clients may be referred to a certified dietitian to receive outpatient medical nutrition therapy. Use the usual professional referral procedures (e.g., a prescription or letter) to refer clients for medically necessary medical nutrition therapy.

HRSA pays for the procedure codes listed below when referred by an EPSDT provider. **Providers must document beginning and ending times that the service was provided in the client's medical record.**

| Procedure Code | Limitations |
|---|---|
| 97802 | 1 unit = 15 minutes; maximum of 2 hours (8 units) per year |
| 97803 | 1 unit = 15 minutes; maximum of 1 hour (4 units) per day |
| 97804 | 1 unit = 15 minutes; maximum of 1 hour (4 units) per day |

# Fluoride Varnish **(HCPCS code D1203)**

Fluoride varnish is a type of topical fluoride that acts to retard, arrest, and reverse the caries process. It is applied up to three times in a 12-month period to all surfaces of the teeth. The teeth absorb the fluoride varnish, strengthening the enamel and helping prevent cavities.

## Who may prescribe the fluoride varnish?

- Dentists;
- Physicians;
- Physician Assistants (PA); or
- Advanced Registered Nurse Practitioners (ARNP).

## Who is eligible?

All Medicaid-eligible clients, age 18 years and younger, may receive fluoride varnish applications. Clients of the Division of Developmental Disabilities (DDD) that are age 19 and older are also eligible.

## Are managed care clients eligible?

Clients whose DSHS Medical ID cards have an identifier in the HMO column are enrolled in one of HRSA's managed health care plans. These clients **are eligible for fluoride varnish applications** through fee-for-service. Bill HRSA directly for fluoride varnish applications.

# Immunizations - Children

**(This applies to clients age 20 years and younger. For clients age 21 years and older, refer to "Immunizations-Adults" on page C.11.)**

Immunizations covered under the EPSDT program are listed in the Fee Schedule. For those vaccines that are available at no cost from the Department of Health (DOH) through the Universal Vaccine Distribution program and the Federal Vaccines for Children program for children 18 years of age and under, HRSA pays only for the administration of the vaccine and not the vaccines themselves. These vaccines are identified in the Comments column of the Fee Schedule as "free from DOH."

You must bill for the administration of the vaccine and for the cost of the vaccine itself as explained in this section.

## Clients 18 years of age and younger – "Free from DOH"

- These vaccines are available at no cost from DOH. Therefore, HRSA pays only for administering the vaccine.

- Bill for the administration by reporting the procedure code for the vaccine given with modifier SL (e.g. 90707 SL). **Effective July 1, 2006,** HRSA pays $5.96 for the administration for those vaccines that are free from DOH and are billed with modifier SL (e.g., 90707 SL).

- DO NOT bill CPT codes 90471-90472 or 90645-90648 for the administration.

**Note:** If an immunization is the only service provided you must only bill for the administration of the vaccine and the vaccine itself (if appropriate). You must not bill an E&M procedure unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M with modifier 25. If you bill an E&M on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M service.

## Clients 18 years of age and younger – "Not free from DOH"

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with these vaccines. HRSA reimburses for the vaccine using HRSA's maximum allowable fee schedule.

- Bill HRSA for the vaccine administration using either CPT codes 90465-90468 or 90471-90472. ***Do not*** bill CPT codes 90465-90468 in combination with CPT codes 90471-90472. HRSA limits reimbursement for immunization administration to a maximum of two administration codes (e.g., one unit of 90465 and one unit of 90466, one unit of 90467 and one unit of 90468, or one unit of 90471 and one unit of 90472).

  **For example:**

  - ✓ One unit of 90465* and one unit of 90466*;
  - ✓ One unit of 90467* and one unit of 90468*; or
  - ✓ One unit of 90471 and one unit of 90472.

**Note:** HRSA pays for the above starred (*) administration codes ***only*** when the physician counsels the client/family at the time of the administration and the vaccine **is not** available free of charge from the Health Department.

- Providers **must** bill the above administration codes on the **same** claim as the procedure code for the vaccine.

## Clients age 19-20 years – All Vaccines

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given. DO NOT use modifier SL with any of the vaccines for clients 19-20 years of age, regardless of whether the vaccine is available free-of-charge from DOH or not. HRSA pays for the vaccine using HRSA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

# Immunizations-Adults

**(This section applies to clients 21 years of age and older. For clients 20 years of age and younger, refer to "Immunizations-Children")**

- Bill HRSA for the cost of the vaccine itself by reporting the procedure code for the vaccine given.

- HRSA reimburses providers for the vaccine using HRSA's maximum allowable fee schedule.

- Bill for the administration of the vaccine using CPT codes 90471 (one vaccine) and 90472 (each additional vaccine). Reimbursement is limited to one unit of 90471 and one unit of 90472 (maximum of two vaccines).

- Providers **must** bill 90471 and 90472 on the **same** claim as the procedure code for the vaccine.

> **Note:** If an immunization is the only service provided you must only bill for the administration of the vaccine and the vaccine itself (if appropriate). You must not bill an E&M procedure unless a significant and separately identifiable condition exists and is reflected by the diagnosis. In this case, bill the E&M with modifier 25. If you bill an E&M on the same date of service as a vaccine administration without modifier 25, HRSA will deny the E&M service.

# Immune Globulins

> **Note:** HRSA does not reimburse immune globulins that are obtained free of charge.

- **RespiGam** – Do not bill CPT code 90379 for RespiGam. You must use HCPCS code J1565.

- **Synagis** (CPT code 90378)

To receive payment for Synagis®, you ***must*** do one of the following:

- Include the 11-digit National Drug Code (NDC) on the claim form when billing HRSA for Synagis® purchased by the provider and administered to the client in the provider's office. Continue to bill using CPT code 90378 for the drug itself. Bill one (1) unit for each 50 mg of Synagis® used.

**- OR -**

## Synagis (Cont.)

- Obtain Synagis® from a HRSA-contracted specialty pharmacy. The pharmacy will bill HRSA directly for the drug and ship it to the provider's office for administration. Providers may then bill HRSA for the administration only. Do not bill HRSA for the drug itself when the drug is billed by the specialty pharmacy. Please check with the pharmacy regarding whether or not they are contracted to bill HRSA directly as contracted pharmacies change often.

HRSA covers Synagis® for those clients younger than one year of age from December 1 – April 30 of any given year without prior authorization (PA). HRSA requires PA for all other time periods and all other age groups. For details regarding the PA process, refer to Section I of HRSA's current *Physician-Related Services Billing Instructions*.

### *National Drug Code Format*

✓ **National Drug Code (NDC)** – The 11-digit number the manufacturer or labeler assigns to a pharmaceutical product and attaches to the product container at the time of packaging. The 11-digit NDC is composed of a 5-4-2 grouping. The first 5 digits comprise the labeler code assigned to the manufacturer by the Federal Drug Administration (FDA). The second grouping of 4 digits is assigned by the manufacturer to describe the ingredients, dose form, and strength. The last grouping of 2 digits describes the package size. **[WAC 388-530-1050]**

✓ The NDC ***must*** contain 11-digits in order to be recognized as a valid NDC. It is not uncommon for the label attached to a drug's vial to be missing "leading zeros." **For example:** The label may list the NDC as 123456789when, in fact, the correct NDC is ***0***1234***0***56789. Make sure that the NDC is listed as an 11-digit number, inserting any leading zeros missing from the 5-4-2 groupings, as necessary. ***HRSA will deny claims for drugs billed without a valid 11-digit NDC.***

### *Electronic 837-P Claim Form Billing Requirements*

Providers must continue to identify the drug given by reporting the drug's CPT or HCPCS code in the **PROFESSIONAL SERVICE Loop 2400, SV101-1 and the corresponding 11-digit NDC in DRUG IDENTIFICATION Loop 2410, LIN02 and LIN03.** In addition, the units reported in the "units" field in PROFESSIONAL SERVICE Loop 2400, SV103 and SV104 must continue to correspond to the description of the CPT or HCPCS code.

### *HCFA-1500 Claim Form Billing Requirements*

If you bill using a **paper** HCFA-1500 claim form for **two or fewer drugs on one claim form,** you must list the 11-digit NDC in ***field 19*** of the claim form **exactly** as follows (*not all required fields are represented in the example*):

| 19. 54569549100 Line 2 / 00009737602 Line 3 |
|---|

| Line | Date of Service | Procedure Code | Charges | Units |
|---|---|---|---|---|
| 1 | 07/01/06 | 99211 | 50.00 | 1 |
| 2 | 07/01/06 | 90378 | 1500.00 | 2 |
| 3 | 07/01/06 | J3420 | 60.00 | 1 |

***DO NOT*** attempt to list more than two NDCs in field 19 on the paper HCFA-1500 claim form. If you bill for more than 2 drugs, you must list the additional drugs on additional claim forms. **You may not bill more than 2 drugs per claim form.**

**If the 11-digit NDC is missing, incomplete, or invalid, the claim line for the drug or supply will be denied.**

- **Hepatitis B** (CPT code 90371) - Reimbursement is based on the number of 1.0 ml syringes used. Bill each 1.0 ml syringe used as 1 unit.

- **Varicella Zoster** (CPT code 90396) - Each one unit billed equals one 125-unit vial, with a maximum reimbursement of five vials per session.

- **Rabies Immune Globulin (RIG) (CPT codes 90375-90376)**

  ✓ RIG is given based on .06 ml per pound of body weight. The dose is rounded to the nearest tenth of a milliliter (ml). Below are the recommended dosages up to 300 pounds of body weight:

| Pounds | Dose |
|---|---|
| 0-17 | 1 ml |
| 18-34 | 2 ml |
| 35-50 | 3 ml |
| 51-67 | 4 ml |
| 68-84 | 5 ml |
| 85-100 | 6 ml |
| 101-117 | 7 ml |
| 118-134 | 8 ml |
| 135-150 | 9 ml |

| Pounds | Dose |
|---|---|
| 151-167 | 10 ml |
| 168-184 | 11 ml |
| 185-200 | 12 ml |
| 201-217 | 13 ml |
| 218-234 | 14 ml |
| 235-250 | 15 ml |
| 251-267 | 16 ml |
| 268-284 | 17 ml |
| 285-300 | 18 ml |

- ✓ RIG is sold in either 2 ml or 10 ml vials.
- ✓ One dose is allowed per episode.
- ✓ Bill one unit for each 2 ml vial used per episode.

**Examples:**

- ✓ If a client weighs 83 pounds, three 2 ml vials would be used. The number of units billed would be three; or
- ✓ If a client weighs 240 pounds, both one 10 ml vial and three 2 ml vials or eight 2 ml vials could be used. The number of units billed would be eight.

- **Correct Coding for Various Immune Globulins –** Bill HRSA for immune globulins using the HCPCS procedure codes listed below. HRSA does not reimburse for the CPT codes listed in the Noncovered CPT Code column below.

| Noncovered CPT Code | Covered HCPCS Code |
|---|---|
| 90281 | J1460-J1560 |
| 90283 | J1566 or J1567 |
| 90291 | J0850 |
| 90379 | J1565 |
| 90384 | J2790 |
| 90385 | J2790 |
| 90386 | J2792 |
| 90389 | J1670 |

# Therapeutic or Diagnostic Injections

**(CPT codes 90760-90779) [Refer to WAC 388-531-0950]**

- If no other service is performed on the same day, you may bill a subcutaneous or intramuscular injection code (CPT code 90772) in addition to an injectable drug code.

- HRSA does not pay separately for intravenous infusion (CPT codes 90772-90779) if they are provided in conjunction with IV infusion therapy services (CPT codes 90760, 90761, or 90765-90768).

- HRSA pays for only one "initial" intravenous infusion code (CPT codes 90760, 90765, or 90774) per encounter unless:

  - ✓ Protocol requires you to use two separate IV sites; or
  - ✓ The client comes back for a separately identifiable service on the same day. In this case, bill the second "initial" service code with modifier 59.

- HRSA does not pay for CPT code 99211 on the same date of service as drug administration CPT codes 90760-90761, 90765-90768, or 90772-90779. If billed in combination, HRSA denies the E&M code 99211. However, you may bill other E&M codes on the same date of service using modifier 25 to indicate that a significant and separately identifiable service was provided. If you do not use modifier 25, HRSA will deny the E&M code.

- **Concurrent Infusion:** HRSA pays for concurrent infusion (CPT code 90768) only once per day.

## Hyalgan/Synvisc

- HRSA reimburses only orthopedic surgeons, rheumatologists, and physiatrists for Hyalgan or Synvisc.

- HRSA allows a maximum of 5 Hyalgan or 3 Synvisc intra-articular injections **per knee** for the treatment of pain in osteoarthritis of the knee. Identify the left knee or the right knee by adding the modifier LT or RT to your claim.

- This series of injections may be repeated at 12-week intervals.

The injectable drug must be billed after all injections are completed.

- Providers must bill for Hyalgan and Synvisc using the following HCPCS codes:

| HCPCS Code | Description | Limitations |
|---|---|---|
| J7317 | Sodium hyaluronate, 20-25 mg, for intra-articular injection (Hyalgan) | Maximum of 5 injections<br>Maximum of 5 units<br>(1 unit = 1 injection of 20-25 mg) |
| J7320 | Hylan G-F 20, 16 mg, for intra-articular injection (Synvisc) | Maximum of 3 injections<br>Maximum of 3 units<br>(1 unit = 1 injection of 16 mg) |

- Hyalgan and Synvisc injections are covered for treatment of osteoarthritis of the knee only with the following ICD-9-CM diagnosis codes:

| Diagnosis Code | Description |
|---|---|
| 715.16 | Osteoarthritis, localized, primary lower leg. |
| 715.26 | Osteoarthritis, localized, secondary, lower leg. |
| 715.36 | Osteoarthritis, localized, not specified whether primary or secondary, lower leg. |
| 715.96 | Osteoarthritis, unspecified whether generalized or localized, lower leg. |

- The injectable drugs must be billed after all injections are completed.

- Bill CPT injection code 20610 each time an injection is given, up to a maximum of 5 injections for Hyalgan or 3 injections for Synvisc.

- You must bill both the injection CPT code and HCPCS drug code on the same claim form.

## Clarification of Coverage Policy for Certain Injectable Drugs

In certain circumstances, HRSA limits coverage for some procedures and/or injectable drugs given in a physician's office to specific diagnoses or provider types only. This policy is outlined in previous memoranda. Although specific memoranda have been superseded, the policy regarding limited coverage for some procedures and/or injectable drugs remains in effect.

Limitations on coverage for certain injectable drugs are listed below:

| Procedure Code | Brief Description | Limitation Restricted to ICD-9-CM |
|---|---|---|
| J0637 | Caspofungin acetate | 117.3 (aspergillosis) |
| J0725 | Chorionic gonadotropin/1000u | 752.51 (Undescended testis) |
| J1055 | Medroxyprogester acetate inj (depo provera) | Females-only diagnoses V25.02 or V25.49 or V25.9. (contraceptive mgmt) Males-diagnosis must be related to cancer |
| J1212 | Dimethyl sulfoxide 50% 50 ML | 595.1 (chronic intestinal cystitis) |
| J1595 | Injection glatiramer acetate | 340 (multiple sclerosis) |
| J1756 | Iron sucrose injection | 585.1-585.9 (chronic renal failure) |
| J2325 | Nesiritide | No diagnosis restriction. Restricted use only to cardiologists |
| J2501 | Paricalcitol | 585.6 (chronic renal failure) |
| J2916 | Na ferric gluconate complex | 585.6 (chronic renal failure) |
| J3285 | Treprostinil, 1 mg | 416.0-416.9 (chronic pulmonary heart disease) |
| J3420 | Vitamin B12 injection | 123.4, 151.0-154.8, 157.0-157.9, 197.4-197.5, 266.2, 281.0-281.3, 281.9, 284.0, 284.8-284.9, 555.9, 579.0-579.9, 648.20-648.24 |
| J3465 | Injection, voriconazole | 117.3 (aspergillosis) |
| J3487 | Zoledronic acid | 198.5, 203.00-203.01, and 275.42 (hypercalcemia) |
| J9041 | Bortezomib injection | 203.00-203.01 (multiple myeloma and immunoproliferative neoplasms) |
| Q3025 | IM inj interferon beta 1-a | 340 (multiple sclerosis) |
| Q3026 | Subc inj interferon beta-1a | 340 (multiple sclerosis) |

### Clarification of Coverage Policy for Miscellaneous Procedures

- Limitations on coverage for certain miscellaneous procedures are listed below:

| Procedure Code | Brief Description | Limitation Restricted to ICD-9-CM |
|---|---|---|
| 11980 | Implant hormone pellet(s) | 257.2 and 174.0-174.9 |
| S0139 | Minoxidil, 10 mg | 401.0-401.9 (essential hypertension) |
| S0189 | Testosterone pellet 75 mg | 257.2, 174.0-174.9 and only when used with CPT code 11980 |

## Verteporfin Injection (HCPCS code J3396)

Verteporfin injections are limited to ICD-9-CM diagnosis code 362.52 (exudative senile macular degeneration).

## Clozaril Case Management

- Providers must bill for Clozaril case management using CPT code 90862 (pharmacologic management).
- HRSA reimburses only physicians, psychiatrists, ARNPs, and pharmacists for Clozaril case management.
- HRSA reimburses providers for one unit of Clozaril case management per week.
- HRSA reimburses providers for Clozaril case management when billed with ICD-9-CM diagnosis codes 295.00 – 295.95 only.
- Routine venipuncture (CPT code 36415) and a blood count (CBC) may be billed in combination when providing Clozaril case management.
- HRSA does not pay for Clozaril case management when billed on the same day as any other psychiatric-related procedures.

# Botulism Injections **(HCPCS code J0585 and J0587)**

HRSA requires PA for HCPCS codes J0585 and J0587 **regardless of the diagnosis**.

HRSA approves Botulism injections with prior authorization:

- For the treatment of:
  - ✓ Cervical dystonia;
  - ✓ Blepharospasm; and
  - ✓ Lower limb spasticity associated with cerebral palsy in children; and
- As an alternative to surgery in patients with infantile esotropia or concomitant strabismus when:
  - ✓ Interference with normal visual system development is likely to occur; and
  - ✓ Spontaneous recovery is unlikely.

# Using the On-line General Store

1. Go to the Department of Printing website at www.prt.wa.gov.

2. Click ***General Store***. Register if you are new to the site or sign in. Write down your login for future use.

3. You will be given an option to shop by agency or item type. Click ***Shop by Agency***.

4. Click ***Department of Social and Health Services***, then ***Health and Recovery Services Administration***, then ***Publications*** or ***Forms*** whichever is the product you wish to order. You will then have a list of publications or forms by number.

5. Select the item you wish and place it in your shopping cart by clicking on ***Add to Cart***.

   **VERY IMPORTANT!!** YOU MUST click on the ***Update Cart*** button located below your list of items in your cart. If the button is not visible due to multiple items being in your cart, use the scroll buttons on the right to scroll down until it is visible. If you do not click on the ***Update Cart*** button, you will only receive 1 of each item ordered.

6. You may continue shopping and adding items to your cart, or you may click the ***Check Out*** button.

7. Enter your shipping information on the next screen. Be sure the first time you use the cart you enter your primary shipping information. This will be Address 1 and the default information that will appear each time you check out. You may add other addresses by selecting ***New Address*** in the "Select Address" window and filling in the information. Write down what the new address number is and you can have it automatically filled in by choosing that address number. Then click the ***Total*** button.

The preferred method of ordering is on-line through the Department of Printing's General Store. You may also send orders by email to fulfillment@prt.wa.gov, by phone at 360.586.6360, or fax at 360.586.8831. Please order online if at all possible.

**Useful web addresses:**

- HRSA Publications website http://maa.dshs.wa.gov/CustomerPublications/
- DSHS Forms http://www1.dshs.wa.gov/msa/forms/

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